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JAMES W. HOLSINGER, JR., M.D.
SECRETARY

April 7, 2004

Community Mental Health Clinics
Substance Abuse Providers
Provider Letter # A- 69

Dear Community Mental Health Center Substance Abuse Provider,

On November 25, 2003 the emergency regulation 907 KAR 3:110E governing the Medicaid substance abuse and pregnancy/postpartum benefit expired and the ordinary regulation 907 KAR 3:110 became effective. As a result of some of the changes made, questions have arisen about whether pregnant or postpartum clients who qualify for selective and indicated prevention services can still receive the "reducing-harm-to-the-fetus" universal prevention protocol.

Section 4, subsection (2), paragraph (b) of 907 KAR 3:110 indicates that a "reducing-harm-to-the-fetus" protocol is to be delivered to clients who meet the admission criteria for universal prevention services. The descriptions of selective and indicated prevention services found in Section 4, subsection 2, paragraphs (c) and (d) no longer make a specific reference to delivering a "reducing-harm-to-the-fetus" protocol.

The Department for Medicaid Services wishes to clarify that the universal prevention "reducing-harm-to-the-fetus" protocol can be delivered as part of selective and indicated prevention services because these services also require addressing risks related to substance use during pregnancy as indicated below:

1. In Section 4, subsection (2), paragraph (c), subparagraph 1., the definition of the therapeutic risk reduction protocol for selective prevention services states, "Shall consist of a therapeutic risk reduction protocol that is designed to reduce the risk that an individual will use alcohol, tobacco, or another drug during pregnancy, thus protecting the child from subsequent risk for harm."; and

2. In Section 4, subsection (2), paragraph (d), subparagraph 1, clause a, subclause (i), the description of the therapeutic risk reduction protocol for indicated prevention services includes the requirement to, "Address the health and social consequences of high-risk drinking or drug choices, including consequences to a fetus in the case of any alcohol or drug use during pregnancy."

When the universal prevention "reducing-harm-to-the-fetus" protocol is delivered to persons receiving selective and indicated prevention services it should be coded as a universal prevention service not a selective or indicated prevention service.

It is also the decision of the Department for Medicaid Services that the assigned professional modifier U6 (Alcohol and Drug Counselor) along with the modifier HN (bachelor degree) be used for all Bachelor degree level prevention and treatment personnel delivering a substance abuse service.

If you have any questions regarding this letter of clarification, please feel free to contact Jennifer Smith with the Division of Medicaid Services for Mental Health and Mental Retardation at (502) 564-5198.

Sincerely,

Russ Fendley by L Flynn

Russ Fendley,
Commissioner

907 KAR 3:110. Community mental health center substance abuse services.

RELATES TO: KRS 205.520(3)

STATUTORY AUTHORITY: KRS 194A.030(3),(5), 194A.050(1), 42 C.F.R. 440.130, 440.210, 440.250, 447.325, 42 U.S.C. 1396a-d

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet by administrative regulation to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the eligibility criteria, schedule of benefits, payment methodology and qualifications and criteria for the provision of substance abuse services.

Section 1. Definitions. (1) "Cabinet" means the Cabinet for Health Services.

(2) "College or university" means an institution that is:

(a) Accredited by one (1) of eleven (11) regional accrediting organizations recognized by the U.S. Department of Education, Office of Postsecondary Education; and

(b)1. If a Kentucky institution, licensed by the Kentucky Council on Postsecondary Education or the Kentucky Board for Proprietary Education; or

2. If an out-of-state institution, licensed in its home state if licensure is required in that state.

(3) "Department" means the Department for Medicaid Services or its designated agent.

(4) "Division" means the Division of Substance Abuse within the Department for Mental Health and Mental Retardation Services.

(5) "Indicated prevention service" means protocols designed to meet the needs of the individuals identified in Section 6(1)(d)2, 3 or 4 of this administrative regulation in order to reduce or eliminate alcohol and drug use during pregnancy and lactation and reduce subsequent onset or continuation of substance abuse.

(6) "Individual" means a pregnant woman, or a postpartum woman for a sixty (60) day period after pregnancy ends and any remaining days in the month in which the 60th day falls, who has applied for or is receiving substance abuse services through Medicaid.

(7) "Prevention Protocol Review Panel" means a panel of substance abuse prevention experts, composed of a representative appointed by the cabinet secretary and representatives from the division, who review and approve risk reduction protocols.

(8) "Qualified preventionist" means a staff member of a provider agency who provides substance abuse prevention services and meets the qualifications in accordance with Section 7(1) of this administrative regulation.

(9) "Qualified substance abuse treatment professional" means a staff member of a provider agency who conducts a clinical assessment, develops a treatment plan, leads a therapy session, or provides a case-management service and who meets the requirements in Section 7(2) of this administrative regulation.

(10) "Selective prevention service" means protocols targeted:

(a) At preventing alcohol and drug related problems during pregnancy, lactation and throughout life for individuals who have identified themselves as a member of a subgroup:

1. Known to be at increased risk for substance abuse; and

2. Identified in Section 6(1)(c)2 of this administrative regulation; and

(b) For the entire subgroup regardless of the specific degree of risk of any particular individual.

(11) "Substance abuse" means alcohol and other drug abuse as defined in KRS 222.005(12).

(12) "Substance abuse prevention service" means, in accordance with Section 4 of this administrative regulation, a universal, selective or indicated prevention service for the purpose of reducing risk that a fetus may experience health problems due to in utero exposure to alcohol, tobacco or another drug and, for selective and indicated populations, reducing the risk that an individual may experience alcohol or other drug-related problems throughout life.

(13) "Substance abuse treatment service" means outpatient, intensive outpatient, day rehabilitation, case management or community-support services in accordance with the requirements in Section 4 of this administrative regulation.

(14) "Substance-related disorder" means the formal diagnosis of substance abuse or substance dependency, excluding nicotine dependence, with a substance-related disorder diagnosis code in accordance with 45 C.F.R. 162.1000.

(15) "Therapeutic risk reduction protocol" means a behavior change regimen using research-based strategies which have been demonstrated to produce desired attitudinal or behavioral outcomes that halt progression toward substance dependency and reduce risk for other alcohol and drug related problems in specific targeted populations.

(16) "Triage" means a telephone or face-to-face interview with an applicant for services or a referral source to:

(a) Determine the nature of the presenting problem;

(b) Determine the immediacy of the need for services; and

(c) Refer the individual for a substance abuse assessment.

(17) "Universal prevention service" means the provision of information:

(a) To individuals who share the general risk for using alcohol, tobacco or other drugs, although the risk may vary greatly among individuals; and

(b) That is aimed at preventing the use of alcohol, tobacco or other drugs during pregnancy and lactation.

Section 2. Eligibility Criteria. A person shall be eligible to receive the substance abuse services covered under this administrative regulation if the individual:

(1) Meets Medicaid eligibility requirements established in 907 KAR 1:605;

(2) Is a pregnant woman or a postpartum woman for a sixty (60) day period after pregnancy ends and any remaining days in the month in which the 60th day falls; and

(3) Meets the service placement criteria in Section 6 of this administrative regulation.

Section 3. Provider Participation Requirements. A provider providing substance abuse services in accordance with Section 4 of this administrative regulation shall:

(1) Be a community mental health-mental retardation center:

(a) Established in accordance with KRS 210.380; and

(b) Which provides services either:

1. Directly in accordance with the following licensure administrative regulations:

a. 908 KAR 1:370 for substance abuse treatment services; or

b. 908 KAR 1:380 for substance abuse prevention services; or

2. Indirectly through a subcontractor who shall adhere to the following contractual requirements:

a. If providing a substance abuse treatment service, be:

(i) Licensed in accordance with 908 KAR 1:370; or

(ii) Licensed in accordance with 902 KAR 20:160 or KRS Chapter 216B and comply with the applicable standards of 908 KAR 1:370; or

b. If providing a substance abuse prevention service, be:

(i) Licensed in accordance with 908 KAR 1:380; or

(ii) A local health department under the authority of KRS 211.180 and 211.190; and

(2) Comply with service access standards established in Section 5 of this administrative regulation.

Section 4. Substance Abuse Services. The following services shall be covered in accordance with this administrative regulation.

(1) Assessment.

(a) An assessment shall:

1. Be completed by a qualified substance abuse treatment professional; and

2. Be provided for an individual prior to receiving a substance abuse treatment service or an indicated prevention service.

(b) For an individual receiving an assessment, the assessment shall include an interview on the:

1. Current level of substance intoxication or withdrawal;

2. Current pattern of substance use including quantity, frequency, and personal use history;

3. Identification of household members and significant others in the individual's life who use alcohol and other drugs;

4. Family history of alcohol and drug abuse;

5. History of emotional, sexual and physical abuse including current needs for safety;

6. History of mental health problems and diagnoses; and

7. Utilization of prenatal care and pediatric care for newborns.

(c) For an individual assessed as showing current substance use or giving evidence of risk for substance abuse based on any of the items in paragraph (b) of this subsection, the assessment shall include the following additional information:

1. Psychosocial history including:

a. Presenting need;

b. Current living arrangements;

c. Marital and family history;

d. History of involvement with child and adult protective services;

e. Current custody status of an individual's children;

f. Legal, employment, military, educational, and vocational history;

g. Peer group relationships;

h. Religious background and practices;

i. Ethnic and cultural background;

j. Leisure and recreational activities; and

k. Individual strengths and limitations;

2. Current physical health status; and

3. Completion of a mental status screening.

(d) For an individual assessed in accordance with paragraphs (b) and (c) of this subsection, an integrated written summary shall be developed that documents an individual's need for services and includes:

1. Pregnancy or postpartum status; and

a. A primary diagnosis of a substance-related disorder requiring treatment services; or

b. The need for substance abuse prevention services; and

2. The individual's need for:

a. Prenatal care;

b. A screening for health care problems for a postpartum woman;

c. Pediatric care;

d. Mental health, mental retardation or developmental disability services; or

e. Community services to meet immediate needs for safety, food, clothing, shelter or medical care.

(e) Development of an initial plan of care shall include the following:

1. The presenting need or problem; and

2. Substance abuse services needed by the individual as established by the assessment findings and the service placement criteria in Section 6 of this administrative regulation to include:

a. An explanation of how this individual meets the admission criteria for this service;

b. The name of the provider to whom the individual as established by the assessment fin individual is being referred for this service; and

c. The determination of the immediacy of the individual's need to receive the services based on the following criteria and in accordance with the access requirements established in Section 5 of this administrative regulation:

(i) Emergency need. Emergency need shall indicate a substance-related condition that may result in serious jeopardy to the life or health of an individual or a fetus, harm to another person by an individual, or inability of an individual to seek food or shelter;

(ii) Urgent need. Urgent need shall indicate a clinical condition that does not pose an immediate risk of harm to self or another person but requires a rapid clinical response in order to prevent onset of an emergency condition;

(iii) Routine need. A routine need shall pose no immediate risk of harm to self or another person but requires a clinical response;

(iv) Universal, selective, and indicated prevention services. A provider agency shall provide access to a substance abuse universal, selective or indicated prevention service within a thirty (30) day period of a request for a service for an individual.

(f) The completed assessment and initial plan of care shall be forwarded to the substance abuse treatment or prevention provider within five (5) working days.

(2) Prevention services.

(a) General requirements for universal, selective, and indicated prevention services. A prevention service shall:

1. Be delivered as an individual or group service;

2. Utilize a protocol approved by the division for a period of two (2) years and reevaluated at the end of that time by the Protocol Review

Panel to determine its continued use; and

3. Be delivered as a face-to-face contact between an individual and a qualified preventionist who meets the requirements in Section 7 (1) of this administrative regulation.

(b) Universal prevention services:

1. Shall consist of a protocol for reducing harm to the fetus that:

a. Is designed to reduce the risk that an individual will use alcohol, tobacco or another drug during pregnancy or the postpartum period, thus protecting the child from subsequent risk for harm;

b. Identifies specific risks associated with alcohol, tobacco or another drug use during pregnancy and lactation, including risks to a fetus, such as low birth weight and fetal alcohol spectrum disorder;

c. Identifies signs of postpartum depression and addresses the risk for substance abuse following pregnancy; and

d. Reduces the shame and stigma attached to addressing alcohol and drug issues to encourage an individual to pursue additional needed substance abuse prevention and treatment services;

2. May include a process for the identification of an individual needing a referral for a selective prevention service or a substance abuse assessment completed in accordance with subsection (1)(b) and (c) of this section; and

3. Shall have reimbursement limited to no more than two (2) hours during a single pregnancy and postpartum period.

(c) Selective prevention services:

1. Shall consist of a therapeutic risk reduction protocol that is designed to reduce the risk that an individual will use alcohol, tobacco, or another drug during pregnancy, thus protecting the child from subsequent risk for harm.

a. The therapeutic risk reduction protocol shall:

(i) Increase the perception of personal risk for harm due to high-risk alcohol and drug use throughout life;

(ii) Identify the levels of alcohol and drug use that increase risk for problems during pregnancy and throughout life;

(iii) Address health and social consequences of high-risk drinking or drug choices; and

(iv) Address biological, psychological, and social factors that may increase risk for alcohol and other drug use during pregnancy and lactation and alcohol and other drug abuse throughout life; and

b. While not mandatory, it is desirable that the therapeutic risk reduction protocol also include information to help the individual:

(i) Change perceptions of normative alcohol and other drug behaviors;

(ii) Develop skills for making and maintaining behavioral changes in alcohol and drug use and in developing social and psychological supports for these changes throughout life; or

(iii) Address parental influences on alcohol and drug choices of children, family management issues, and the establishment of successful expectations and consequences;

2. May include a process for the identification of an individual needing a referral for a substance abuse assessment completed in accordance with subsection (1) of this section;

3. Reimbursement shall be limited to:

a. During a single pregnancy and postpartum period; and

b. A maximum of seventeen (17) hours for a therapeutic risk reduction protocol targeted at preventing alcohol and drug problems throughout the life of the individual.

(d) Indicated prevention service:

1. Shall consist of a therapeutic risk reduction protocol which is designed to reduce the risk that certain individuals may experience alcohol and other drug related health problems, including substance dependency or experience alcohol and other drug related impairments throughout life:

a. A therapeutic risk reduction protocol shall:

(i) Address the health and social consequences of high-risk drinking or drug choices, including consequences to a fetus in the case of any alcohol or drug use during pregnancy;

(ii) Increase the perception of personal risk for harm due to high-risk alcohol and drug use;

(iii) Identify the existence of biological, psychological, and social risk factors; and

(iv) Identify levels of alcohol and other drug use that increase risk for problems; and

b. A therapeutic risk reduction protocol for an indicated prevention service may include:

(i) Changing perceptions of normative alcohol and drug use behaviors;

(ii) Developing skills for making and maintaining behavioral changes, including changes in alcohol and drug use, and developing social and psychological supports to maintain the changes throughout life; and

(iii) Addressing parental influences on the alcohol and drug choices of children, family management issues, and the establishment of successful expectations and consequences; and

2. Reimbursement shall be limited to:

a. During a single pregnancy and postpartum period; and

b. A maximum of twenty-five (25) hours for a protocol targeted at prevention of alcohol and drug problems throughout the life of the individual.

(3) Outpatient services.

(a) An outpatient service shall be an ambulatory care service that:

1. Is a face-to-face therapeutic interaction between an individual and a qualified substance abuse treatment professional; and

2. Is for the purpose of reducing or eliminating a substance abuse problem and shall include the following services:

a. Treatment planning;

b. Referrals for other needed health and social services;

c. Information on substance abuse and its effects on health and fetal development;

d. Orientation to substance abuse related self-help groups; and

e. Participation in one (1) or more of the following modalities of outpatient treatment:

(i) Individual therapy;

(ii) Group therapy;

(iii) Family therapy. This modality shall be provided to an individual and one (1) or more persons with whom an individual has a family relationship;

(iv) Psychiatric evaluation provided by a psychiatrist or advanced registered nurse practitioner (ARNP);

(v) Psychological testing provided by a licensed psychologist who holds the designation of health service provider, certified psychologist with autonomous functioning, certified psychologist, licensed psychological practitioner, or licensed psychological associate;

(vi) Medication management provided by a physician or an advanced registered nurse practitioner; or

(vii) Collateral care. This modality shall provide face-to-face consultation or counseling to a person who is in a position of custodial control or supervision of an individual under age twenty-one (21), in accordance with an individual's treatment plan.

(b) Service limitations.

1. Group therapy.

a. There shall be no more than twelve (12) persons in a group therapy session.

b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse and other self-help groups.

2. Collateral care shall be limited to individuals under age twenty-one (21).

3. Psychiatric evaluations or psychological testing that do not result in an individual receiving substance abuse treatment shall not be reimbursable through this benefit.

4. No more than eight (8) hours of outpatient services shall be reimbursed during a one (1) week period.

(4) Intensive outpatient services.

(a) An intensive outpatient service shall be an ambulatory care service for the purpose of reducing or eliminating an individual's substance abuse problem.

(b) The following components shall be provided in an intensive outpatient service as a face-to-face therapeutic interaction between an individual and a qualified substance abuse treatment professional:

1. Treatment planning;

2. A structured program of information on substance abuse and its effects on health, fetal development and family relationships which shall be provided either to an individual or an individual and one (1) or more persons with whom an individual has a close association; and

3. Individual, group and family therapy.

(c) The following components may be provided in an intensive outpatient service as a face-to-face activity between an individual and a qualified substance abuse treatment professional or a member of the therapeutic team, supervised by a qualified substance abuse treatment professional:

1. Independent living skills training;

2. Parenting skill development;

3. Orientation to substance abuse and other self-help programs; or

4. Staff support to activities led by the individual.

(d) Service limitations.

1. Group therapy.

a. There shall be no more than twelve (12) persons in a group therapy session.

b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse or other self-help groups.

2. Reimbursement for an intensive outpatient service shall be limited to no more than seven (7) hours per day not to exceed forty (40)

hours per week.

(5) Day rehabilitation services.

(a) A day rehabilitation service shall be provided in a residential facility for the purpose of reducing or eliminating an individual's substance abuse problem.

(b) The following components shall be provided in a day rehabilitation service as a face-to-face therapeutic interaction between an individual and a qualified substance abuse treatment professional:

1. Treatment planning;

2. A structured program of information on substance abuse and its effects on health, fetal development and family relationships which shall be provided to either an individual or an individual and one (1) or more persons with whom an individual has a close association; and

3. Individual, group and family therapy.

(c) The following components may be provided in a day rehabilitation service but shall be provided as a face-to-face activity between an individual and a qualified substance abuse treatment professional or a member of the therapeutic team, supervised by a qualified substance abuse treatment professional:

1. Independent living skills training;

2. Parenting skill development;

3. Orientation to substance abuse and other self-help programs; or

4. Staff support to activities led by the individual.

(d) Service limitations.

1. In accordance with 42 U.S.C. 1396d(a) and 1396d(i), payment shall not be made for care or services for any individual who is a patient in an institution of more than sixteen (16) beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.

2. Group therapy.

a. There shall be no more than twelve (12) persons in a group therapy session.

b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse or other self-help groups.

3. Reimbursement for a day rehabilitation service shall be limited to no more than eight (8) hours per day not to exceed forty-five (45) hours per week.

4. Room and board costs shall not be covered under this benefit.

(6) Case-management services.

(a) Case management shall be an ambulatory care service that:

1. Shall be a minimum of four (4) face-to-face or telephone contacts per month between or on behalf of an individual and a qualified substance abuse treatment professional, of which:

a. At least two (2) of the contacts shall be face to face with the individual; and

b. The remaining contacts shall be by phone or face to face with or on behalf of the individual; and

2. Is for the purpose of reducing or eliminating an individual's substance abuse problem by assisting an individual in gaining access to needed medical, social, educational and other support services.

(b) Case-management services shall include:

1. An assessment of an individual's case-management needs;

2. Development of a service plan that identifies an individual's case management projected outcomes; and

3. Activities that support the implementation of an individual's service plan.

(c) Case-management services shall not be connected with a specific type of substance abuse treatment but shall follow an individual across the array of substance abuse treatment services identified in the individual's treatment plan.

(d) Service limitations. The following activities shall not be reimbursed by this Medicaid benefit:

1. An outreach or case-finding activity to secure a potential individual for services;

2. Administrative activities associated with Medicaid or eligibility determinations;

3. Transportation services solely for the purpose of transporting the individual; and

4. The actual provision of a service other than a case-management service.

(7) Community-support services.

(a) A community-support service shall be an ambulatory care service that shall be provided if the service is identified as a need in the individual's case-management service plan.

(b) A community-support service shall be a face-to-face or telephone contact between an individual and a qualified community-support provider, who meets the requirements in Section 7(4) of this administrative regulation.

(c) A community-support service shall include:

1. Assisting the individual in remaining engaged with substance abuse treatment or community self-help groups;

2. Assisting the individual in resolving a crisis in the individual's natural environment; and

3. Coaching the individual in her natural environment to:

a. Access services arranged by a case manager; and

b. Apply substance abuse treatment gains, parent training and independent living skills to the individual's personal living situation.

(d) A community-support provider shall coordinate the provision of community-support services with the individual's primary provider of case-management services.

(e) Service limitation. Transportation services solely for the purpose of transporting an individual shall not be reimbursed through this Medicaid benefit.

(8) Service limitation for all substance abuse services. Reimbursement for a substance abuse service shall not be payable for an individual who is a resident in a Medicaid-reimbursed inpatient facility.

Section 5. Access to Substance Abuse Services. A provider agency shall operate a triage component that meets the following requirements:

(1) The provider agency shall maintain telephone access to services twenty-four (24) hours a day, seven (7) days a week through a toll free telephone number that shall be made available to a Medicaid-eligible recipient; and

(2) Triage procedures shall include:

(a) Access to a substance abuse assessment on either an emergency, urgent or routine basis as established in Section 4(1)(e) of this administrative regulation in accordance with the following:

1. Emergency need. A provider agency shall provide access to a substance abuse assessment on an emergency basis within three (3) hours of receiving a request for a service for an individual;

2. Urgent need. A provider agency shall provide access to a substance abuse assessment on an urgent basis within a twenty-four (24) hour period of a request for a service for an individual;

3. Routine need. A provider agency shall provide access to a substance abuse assessment on a routine basis within a forty-eight (48) hour period of a request for a service for an individual; and

(b) Determination of the individual's current Medicaid status.

Section 6. Service Placement Criteria. The following criteria shall be utilized to determine the most appropriate services to meet an individual's needs.

(1) Admission criteria.

(a) General admission criteria. The following criteria shall apply to prevention and treatment services reimbursed under this administrative regulation:

1. An individual shall not have a medical or psychiatric condition that requires immediate medical care in order for the individual to benefit from an identified service;

2. An individual shall not at high risk for harm to self or others or the level of risk can be adequately managed with the parameters of the identified service;

3. An individual may benefit from participation in the identified prevention or treatment service; and

4. An individual referred to outpatient, intensive outpatient, and day rehabilitation services shall not be experiencing alcohol or drug intoxication or withdrawal symptoms that required detoxification in a nonmedical twenty-four (24) hour facility or inpatient medical facility.

(b) Universal prevention services. Universal prevention services shall require that an individual meet the general admission criteria and:

1. Has no identified biological, psychological, or social factors which would increase risk for initiating use of alcohol or other drugs during pregnancy;

2. Has no identified history of personal use of substances that has contributed to a lifestyle, legal problem, or other symptom indicating the need for a substance abuse prevention or treatment service; and

3. Does not meet the criteria for an identified substance-related disorder.

(c) Selective prevention service. Selective prevention services shall require that an individual:

1. Meet the general admission criteria;

2. Gives evidence of risk of substance abuse as defined by:

a. Identification of household members and significant others in the individual's life who use alcohol and other drugs;

b. Family history of alcohol and drug abuse;

c. History of emotional, sexual, and physical abuse; or

d. History of mental health problems and diagnosis; and

3. Has not admitted using alcohol or other drugs during the last thirty (30) days.

(d) Indicated prevention service. Indicated prevention service shall require that an individual meet the general admission criteria and:

1. Has received a substance abuse assessment;

2. Has used alcohol or other drugs since learning of her pregnancy or has exhibited problematic behaviors prior to pregnancy associated with substance use;

3. Has exhibited risk factors that increase her chances of developing a substance abuse problem; or

4. Meets the criteria for a substance-related disorder and may benefit from this service as an adjunct to outpatient treatment.

(e) Outpatient services. Outpatient services shall require that an individual meet the general admission criteria and:

1. Has met the criteria for a primary substance-related disorder; and

2. May benefit from outpatient substance abuse services or may benefit from outpatient services as a means to:

a. Increase acceptance of the need for a more intensive treatment service; or

b. Maintain treatment until the required intensive treatment service is available.

(f) Intensive outpatient service shall require that an individual:

1. Meets the criteria for a substance abuse related disorder;

2. Has a substance abuse problem requiring structured treatment several days a week; and

3. Does not have a substance abuse problem severe enough that progress in reducing or eliminating the abuse or dependency requires more intensive treatment.

(g) Day rehabilitation service shall require that an individual meet the general admission criteria and:

1. Meets the criteria for a substance-related disorder; and

2. Has a substance abuse problem that requires intensive daily or near-daily structured treatment to reduce or eliminate substance abuse or dependency.

(h) Case management service shall require that an individual:

1. Meets the criteria for a substance-related disorder;

2. Has been referred for admission to an outpatient service, intensive outpatient service, day rehabilitation service or has been discharged from a twenty-four (24) hour facility; and

3. Needs assistance in reducing barriers to entering and staying in substance abuse treatment, or in accessing other resources that are needed to maximize functioning in the community.

(i) Community-support service admission criteria shall be a statement in the case management service plan that describes the need for more intensive contact with substance abuse staff in the individual's natural environment in order to reduce or eliminate substance abuse or dependency.

(2) Continuing stay criteria. Continuing stay criteria shall apply only to substance abuse treatment services that include outpatient, intensive outpatient, day rehabilitation, case management, and community support.

(a) To remain in an identified service level, a qualified substance abuse treatment professional shall review an individual's progress in accordance with the following:

1. For an outpatient service, every ninety (90) days;

2. For an intensive outpatient service, every thirty (30) days;

3. For a day rehabilitation service, every two (2) weeks;

4. For a case management service, every thirty (30) days; and

5. For a community support service, every thirty (30) days.

(b) To remain in an identified service, an individual's progress shall reflect that the individual:

1. Continues to meet the criteria for admission to that particular service as established in subsection (1) of this section;

2. May benefit from continued service; and

3. Exhibits progress in accordance with the following:

a. For an outpatient, intensive outpatient, or day rehabilitation service, the individual is making progress in reducing or eliminating substance abuse or dependency but has not met the treatment goals of this service;

b. For a case management service, the individual is making progress in reducing or eliminating substance abuse or dependency but has not met the goals of the case management service plan; and

c. For a community support service, the individual is making progress in reducing or eliminating substance abuse or dependency but has not met the community support service goals in the case management plan.

(3) Discharge criteria.

(a) Prevention service discharge for universal, selected, or indicated populations. An individual shall be discharged if she:

1. Completes a substance abuse prevention service;

2. Has been identified as having a substance abuse or other type of problem that is severe enough to require more intensive services;

3. Demonstrates an inability to benefit from a prevention service; or

4. Has revoked consent to participate or has withdrawn from the service but does not meet criteria for involuntary hospitalization pursuant to KRS 202A.026.

(b) Treatment service discharge for outpatient, intensive outpatient, day rehabilitation, case management, or community support individuals. An individual shall be discharged if she:

1. Has met treatment goals for outpatient, intensive outpatient or day rehabilitation or service plan goals for case management or community support services;

2. Requires more intensive treatment for outpatient and intensive outpatient services;

3. No longer meets the admission requirements established in subsection (1) of this section; or

4. Has revoked consent to participate or has withdrawn from the service and does not meet criteria for involuntary hospitalization pursuant to KRS 202A.026.

Section 7. Staff Qualifications. Staff who are eligible To provide the substance abuse prevention and treatment services established in Section 4 of this administrative regulation shall meet the following qualifications:

(1) A qualified preventionist shall be a staff member of a provider agency who:

(a) Provides universal, selective or indicated substance abuse prevention services;

(b) Meets the qualifications for the delivery of a reducing-harm-to-the-fetus protocol in accordance with Section 8(1)(a)1 of this administrative regulation, or a therapeutic risk reduction protocol approved by the Kentucky Division of Substance Abuse; and

(c) Meets one (1) of the following requirements:

1. Shall be a prevention professional certified as required by the Kentucky Certification Board of Prevention Professionals;

2. Shall be a substance abuse prevention professional who has a bachelor's degree or greater in any field, from an accredited college or university, who:

a. Meets the training, documentation and supervision requirements in Section 8 of this administrative regulation; and

b. Shall, in order to remain eligible to deliver a substance abuse prevention service, become a certified prevention professional pursuant to the requirements of the Kentucky Certification Board of Prevention Professionals within three (3) years from the date the staff member begins delivering Medicaid substance abuse prevention services;

3. Shall be an alcohol and drug counselor certified by the Kentucky Board of Certification for Alcohol and Drug Counselors in accordance with KRS 309.080 to 309.089, who meets the training and documentation requirements in Section 8 of this administrative regulation; or

4. Shall be a certified or licensed professional identified in subsection (3) of this section, who meets the training and documentation requirements in Section 8 of this administrative regulation.

(2) A qualified substance abuse treatment professional shall be a staff member in a provider agency who conducts a clinical assessment, develops a treatment plan, leads a therapy session, or provides a case-management service. In order to provide these services, the qualified substance abuse treatment professional shall meet one (1) of the following requirements:

(a) Shall be an alcohol and drug counselor certified by the Kentucky Board of Certification for Alcohol and Drug Counselors as required by KRS 309.080 to 309.089;

(b) Shall be a certified or licensed professional identified in subsection (3) of this section who meets the training and documentation requirements in Section 8 of this administrative regulation; or

(c) Shall be an individual who has a bachelors degree or greater in any field, from an accredited college or university, who:

1. Meets the training, documentation and supervision requirements in Section 8 of this administrative regulation; and

2. Shall, in order to remain eligible to deliver a Medicaid substance abuse treatment assessment, case management, outpatient, intensive outpatient or day rehabilitation service, achieve licensure or certification as established in paragraph (a) of this subsection or subsection (3) of this section within three (3) years from the date the staff member begins delivering Medicaid substance abuse treatment services.

(3) A qualified staff member, identified in subsections (1)(c)4 or (2)(b) of this section, who provides substance abuse services shall be licensed or certified as one (1) of the following:

(a) A Kentucky physician licensed in accordance with KRS 311.571 to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties;

(b) A psychiatrist licensed in accordance with KRS 311.571 to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties, who is certified or eligible to apply for certification with the American Board of Psychiatry and Neurology;

(c) A licensed psychologist who holds the health service provider designation in accordance with KRS 319.050;

(d) A certified psychologist with autonomous functioning certified by the Kentucky Board of Examiners of Psychology in accordance with KRS 319.056;

(e) A certified psychologist certified by the Kentucky Board of Examiners of Psychology in accordance with KRS 319.056;

(f) A licensed psychological practitioner licensed by the Kentucky Board of Examiners of Psychology in accordance with KRS 319.056;

(g) A licensed psychological associate licensed by the Kentucky Board of Examiners of Psychology in accordance with KRS 319.064;

(h) A clinical social worker licensed for the independent practice of clinical social work by the Kentucky Board of Social Work in accordance with KRS 335.100;

(i) A social worker certified by the Kentucky Board of Examiners of Social Work in accordance with KRS 335.080;

(j) An advanced registered nurse practitioner licensed by the Kentucky Board of Nursing in accordance with KRS 314.042, with scope of practice in psychiatric or mental health nursing;

(k) A registered nurse licensed by the Kentucky Board of Nursing in accordance with KRS Chapter 314 with a masters degree in

psychiatric nursing from an accredited college or university and two (2) years of full-time clinical experience in psychiatric nursing;

(l) A registered nurse licensed by the Kentucky Board of Nursing in accordance with KRS Chapter 314 with a bachelor of science degree in nursing from an accredited college or university who is certified as a psychiatric and mental health nurse by the American Nurses Association and who has three (3) years of full-time clinical experience in psychiatric nursing;

(m) A registered nurse licensed by the Kentucky Board of Nursing in accordance with KRS Chapter 314, and who has one (1) of the following combinations of education and work experience:

1. A bachelor of science in nursing from a four (4) year program from an accredited college or university and one (1) year clinical work experience in the substance abuse or mental health field;

2. A diploma graduate in nursing and two (2) years clinical work experience in the substance abuse or mental health field; or

3. An associate degree in nursing from a two (2) year program from an accredited college or university and three (3) years clinical work experience in the substance abuse or mental health field;

(n) A marriage and family therapist licensed by the Kentucky Board of Licensure of Marriage and Family Therapists in accordance with the provisions of KRS 335.300 to 335.399;

(o) A professional counselor licensed by the Kentucky Board of Licensed Professional Counselors in accordance with the provisions of KRS 335.500 to 335.599; or

(p) A professional art therapist certified by the Kentucky Board of Certification for Professional Art Therapists in accordance with the provisions of KRS 309.130 to 309.1399.

(4) Community-support staff. A qualified community-support staff member shall be a person working in a participating provider agency who provides community-support services in accordance with Section 4(7) of this administrative regulation and who meets the following minimum requirements:

(a) A high school diploma or general equivalent diploma (GED);

1. Two (2) years supervised experience in a substance abuse treatment setting and knowledge of substance abuse related self-help groups; or

2. An additional forty (40) hours of training on topics listed in Section 8(1)(c) of this administrative regulation; and

(b) Completes the staff training, training documentation and supervision requirements established for community-support staff in Section 8 of this administrative regulation.

Section 8. Staff Training, Training Documentation and Supervision. Staff who are eligible to provide substance abuse prevention or treatment services shall meet the following training, documentation, and supervision requirements:

(1) Training.

(a) Prevention staff training requirements.

1. Prior to delivering a reducing harm to the fetus protocol, a professional identified in Section 7(1)(c) of this administrative regulation shall receive training in the protocol in accordance with standards established by the:

a. Prevention protocol review panel; or

b. Community mental health and mental retardation center, if the prevention protocol review panel has not identified specific requirements.

2. A certified alcohol and drug counselor delivering a selective or indicated prevention protocol shall have twenty-four (24) hours of prevention training within the four (4) years prior to the date of assuming the responsibility for delivering this service. The twenty-four (24) hours of training shall be in the following topic areas:

a. Twelve (12) hours in prevention strategies and procedures; and

b. Twelve (12) hours specific to working with the prevention target populations being served.

3. Prior to being eligible to deliver a substance abuse selective or indicated prevention service, a substance abuse prevention professional with a bachelor's degree or greater in any field from an accredited college or university shall:

a. Enter into a supervisory agreement with a prevention professional certified pursuant to the Kentucky Certification Board of Prevention Professionals in accordance with subsection (3)(b) of this section; and

b. Complete forty-five (45) hours of training on the following topics:

(i) Twelve (12) hours in prevention strategies and procedures;

(ii) Twelve (12) hours specific to working with the prevention target populations being served;

(iii) Twelve (12) hours in the recognition and understanding of substance abuse or dependency and related problems; and

(iv) An additional nine (9) hours in one (1) or more of the training topics identified in subclauses (i), (ii), or (iii) of this clause.

4. A certified or licensed professional, listed in Section 7(3) of this administrative regulation, shall have completed an additional forty-five (45) hours of training in alcohol and other drug abuse within four (4) years prior to the date of assuming responsibility for delivering a selective or indicated prevention protocol. The forty-five (45) hours of training shall be in the following topic areas:

a. Twelve (12) hours in the recognition and understanding of substance abuse or dependency and related problems;

b. Twelve (12) hours in prevention strategies and procedures;

c. Twelve (12) hours specific to working with the prevention target population being served; and

d. An additional nine (9) hours in one (1) or more of the training topics identified in clause a, b, or c of this subparagraph.

(b) Treatment staff training requirements.

1. A certified or licensed professional identified in Section 7(3) of this administrative regulation shall complete eighty (80) hours of training in alcohol and other drug abuse counseling within four (4) years prior to the date of assuming responsibility for conducting clinical assessments, developing treatment plans, leading counseling sessions or providing case-management services, or within two (2) years after assuming these responsibilities.

2. A staff member with a bachelor's degree or greater in any field from an accredited college or university shall:

a. Prior to being eligible to deliver a Medicaid substance abuse treatment assessment, case management, outpatient or intensive outpatient service, or day rehabilitation service, complete forty (40) hours of training on the following topics:

(i) Dynamics and treatment of substance abuse;

(ii) Alcohol and drug abuse recovery issues unique to pregnant women and women with dependent children; and

(iii) Recovery issues unique to females who are HIV positive, intravenous drug users, adolescents, and members of racial, cultural or ethnic groups; and

b. Receive supervision in accordance with subsection (3) of this section.

(c) Community support staff training requirements. Qualified community support staff shall obtain twenty (20) hours of training on:

1. Dynamics and treatment of substance abuse;

2. Information on substance abuse recovery issues unique to pregnant women and women with dependent children;

3. Recovery issues unique to females who are HIV positive, intravenous drug users, adolescents, and members of racial, cultural or ethnic groups;

4. Strategies to defuse resistance;

5. Professional boundary issues with an individual that addresses enabling behaviors; and

6. Protecting a qualified community-support staff member, who may be a recovering substance abuser, from losing his own sobriety.

(2) Training documentation requirements. All staff training hours required in subsection (1) of this section shall be documented in a staff member's training file and shall include the:

(a) Date of the training;

(b) Length of the training event in clock hours;

(c) Learning objectives; and

(d) Name of the training provider.

(3) Supervision requirements.

(a) Supervision for a staff member with a bachelor's degree or greater in any field from an accredited college or university, whether that staff member is a substance abuse prevention professional or a staff member providing substance abuse treatment services, shall:

1. Include a minimum of four (4) hours of face-to-face supervision monthly;

2. Be provided either one on one or in a group setting with other staff members being supervised; and

3. Include a written plan of supervision developed and updated annually for each staff member being supervised that shall:

a. Identify knowledge and skill areas needing development;

b. Identify supervision activities to increase competency in areas of need;

c. Include a dated signature of the qualified supervisor, as required by paragraph (b) or (c) of this subsection, and the signature of the staff member being supervised indicating agreement with the plan; and

d. Include maintenance of a record of each supervisory session for each staff member being supervised which includes the date, length of the session and content of the supervision.

(b) Supervision of a substance abuse prevention professional with a bachelor's degree or greater in any field from an accredited college or university shall:

1. Be provided by a prevention professional certified pursuant to the Kentucky Certification Board of Prevention Professionals;

2. Meet the general requirements established in paragraph (a) of this subsection; and

3. Include at least two (2) of the following methodologies each month:

a. Didactic presentations;

b. Consultation on substance abuse prevention strategies or the recognition of substance abuse related problems;

c. Monitoring a staff member's work with an individual or group of individuals receiving substance abuse prevention services through audio or audio-visual taping;

d. Monitoring a staff member's adherence to the prevention protocol; or

e. A supervisor's direct observation of a staff member's work with an individual or group of individuals receiving substance abuse prevention services.

(c) Supervision of a staff member with a bachelor's degree or greater in any field from an accredited college or university who will provide substance abuse treatment services shall:

1. Be provided by a clinical services supervisor who meets one (1) of the following sets of qualifications:

a. A certified alcohol and drug counselor certified pursuant to KRS 309.080 to 309.089 who has at least two (2) years full-time clinical work experience postcertification; or

b. One of the following licensed or certified professionals who has completed eighty (80) hours of training in alcohol and other drug abuse counseling within four (4) years prior to the date of assuming responsibility as a clinical services supervisor and has documented this training in accordance with the requirements established in subsection (2) of this section:

(i) A Kentucky physician licensed in accordance with KRS 311.571 to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties;

(ii) A psychiatrist licensed in accordance with KRS 311.571 to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties, who is certified or eligible to apply for certification with the American Board of Psychiatry and Neurology;

(iii) A licensed psychologist who holds the health service provider designation in accordance with KRS 319.050(7);

(iv) A certified psychologist with autonomous functioning certified to function without supervision, in an area specified by the Kentucky Board of Examiners of Psychology in accordance with KRS 319.056;

(v) A certified psychologist certified to practice psychology by the Kentucky Board of Examiners of Psychology in accordance with KRS 319.056;

(vi) A licensed psychological practitioner licensed by the Kentucky Board of Examiners of Psychology in accordance with the requirements and limitations established in KRS 319.056;

(vii) A licensed psychological associate with at least three (3) years of full-time postcertification practice certified by the Kentucky Board of Examiners of Psychology in accordance with KRS 319.064;

(viii) A clinical social worker licensed for the independent practice of clinical social work by the Kentucky Board of Social Work in accordance with KRS 335.100;

(ix) A certified social worker with at least three (3) years full-time postcertification clinical practice in psychiatric social work certified by the Kentucky Board of Examiners of Social Work in accordance with KRS 335.080;

(x) An advanced registered nurse practitioner licensed by the Kentucky Board of Nursing in accordance with KRS 314.042, with scope of practice in psychiatric or mental health nursing;

(xi) A registered nurse licensed by the Kentucky Board of Nursing in accordance with KRS Chapter 314 with a masters degree in psychiatric nursing from an accredited college or university and two (2) years of full-time clinical experience in psychiatric nursing;

(xii) A registered nurse licensed by the Kentucky Board of Nursing in accordance with KRS Chapter 314 with a bachelor of science degree in nursing from an accredited college or university who is certified as a psychiatric and mental health nurse by the American Nurses Association and who has three (3) years of full-time clinical experience in psychiatric nursing;

(xiii) A marriage and family therapist licensed by the Kentucky Board of Licensure of Marriage and Family Therapists in accordance with the provisions of KRS 335.300 to 335.399;

(xiv) A licensed professional counselor licensed by the Kentucky Board of Licensed Professional Counselors in accordance with the provisions of KRS 335.500 to 335.599; or

(xv) A professional art therapist certified by the Kentucky Board of Certification of Professional Art Therapists in accordance with the provisions of KRS 309.130 to 309.1399;

2. Meet the general requirements established in paragraph (a) of this subsection; and

3. Include at least two (2) of the following methodologies each month:

a. Didactic presentations;

b. Case consultation;

c. Monitoring a staff member's work with an individual through audio or audio-visual taping;

d. A supervisor's direct observation of a staff member's work with an individual; or

e. A meeting with an individual with whom the staff member is working to determine if she is receiving the services she needs.

(d) Supervision of a qualified community-support staff shall:

1. Be provided by a case manager who meets the qualifications in Section 7(2)(a) or (b) of this administrative regulation;

2. Include a minimum of six (6) hours of face-to-face supervision monthly;

3. Meet the general requirements established in paragraph (a) of this subsection; and

4. Include the following supervision methodologies:

a. Didactic presentations;

b. Case consultation; and

c. A supervisor's direct observation of a community-support staff member's work with an individual, or a meeting between a supervisor and an individual with whom a staff member is working, to determine if the individual is receiving the services she needs from a community-support staff person.

Section 9. Records. Services delivered in accordance with Section 4 of this administrative regulation shall be documented in a service record maintained for each individual and meet the following standards:

(1) The service record shall include documentation of written or verbal verification from a health care provider or her authorized representative of the individual's pregnancy and postpartum status to include:

(a) Name of health care provider or her authorized representative providing the verification;

(b) Anticipated due date or date of delivery; and

(c) Applicable diagnosis code for the individual's pregnancy and postpartum status, in accordance with 45 C.F.R. 162.1000.

(2) All entries in an individual's service record shall be:

(a) Kept current;

(b) Dated;

(c) Entitled according to the service received;

(d) Noted as to starting and ending time for each service rendered; and

(e) Signed by the staff member rendering the service, including his title.

(3) At admission to a substance abuse prevention or treatment service, the following intake information shall be completed and documented in an individual's service record within one (1) working day of her visit:

(a) The individual's name, address and telephone number;

(b) Emergency contact person;

(c) Referral source;

(d) Verification of Medicaid status and medical assistance identification number (MAID);

(e) Social Security number;

(f) Age, gender and ethnic background; and

(g) Presenting need.

(4) Assessment. When a substance abuse assessment is completed in accordance with the requirements of Section 4(1) of this administrative regulation, the assessment shall be documented.

(5) Substance abuse prevention services.

(a) If receiving a selective or indicated prevention service, an individual's risk factors for developing alcohol and drug related problems shall be documented.

(b) An individual's behavioral outcomes shall be identified and address the risks associated with using alcohol, tobacco and other drugs during pregnancy and lactation and throughout her lifetime.

(c) A prevention service selected for an individual shall be documented and include an explanation of how the individual meets the admission criteria for that service.

(d) The name of the substance abuse prevention protocol selected for use with an individual shall be documented.

(e) An individual's progress towards meeting her learning objectives shall be documented in her record in accordance with the following:

1. Documentation shall occur within one (1) working day following the delivery of each session;

2. Describe the session's activities, an individual's participation, reaction and progress during the session; and

3. If the prevention service is provided in a group setting, a summary of the session's activities may be copied and placed in each individual's record. An individualized note describing an individual's participation, reaction and progress during the group session shall also be placed in the individual's record. A progress note shall not include the name of any other group member.

(f) Referrals made to other service providers shall be documented.

(g) A discharge summary shall:

1. Be completed following either an individual's withdrawal from or completion of a substance abuse prevention protocol;

2. Be completed within ten (10) days following discharge; and

3. Include a discussion of an individual's progress towards meeting the expected outcomes of the protocol and any recommendations and referrals for other needed services.

(6) Substance abuse treatment services. For an individual receiving a substance abuse outpatient, intensive outpatient, day rehabilitation, case-management or community-support service, the following information shall be documented in the individual's service record by the staff member providing the service:

(a) The treatment plan;

(b) The case-management service plan if the individual is receiving case-management services;

(c) Review and revisions of the treatment or case-management service plan;

(d) The individual's progress towards meeting the objectives of the treatment plan or case-management service plan, documented within one (1) working day and recorded according to the following:

1. Outpatient, case-management and community-support services.

a. A substance abuse treatment professional shall prepare a progress note to include an observation of the individual's behavior and response to the service, and the individual's progress toward meeting the goals and objectives of her treatment plan or case-management service plan.

b. If group therapy is provided, the individual's progress note may include a summary of the session's activities that is copied and placed in each group member's record. An individualized note describing each individual's participation, reaction and progress during the group session shall also be placed in the individual's record. A progress note shall not include the name of another group member.

2. Intensive outpatient and day rehabilitation service.

a. Documentation of the individual counseling session shall meet the progress note documentation requirements in subparagraph 1a of this paragraph.

b. For other treatment activities in an intensive outpatient service, a summary note of the individual's progress may be recorded weekly and shall include:

(i) The eligible treatment activities in which the individual participated during the week;

(ii) Observations of the individual's behavior in response to these services; and

(iii) The individual's progress in meeting her treatment goals and objectives;

(e) An aftercare plan that shall include identification of the individual's service needs at discharge, and activities and referrals supporting recovery from substance abuse; and

(f) A discharge summary that shall be completed within ten (10) days of discharge on the individual seen in excess of three (3) visits, and shall include the:

1. Date of admission and discharge;

2. Presenting problem;

3. Diagnosis;

4. Summary of the individual's treatment and response to treatment; and

5. Referrals made to other service providers.

(7) Confidentiality of an individual's service record. Information in an individual's service record shall be kept confidential in accordance with 908 KAR 1:320.

(8) Right to inspect records for audit and evaluation purposes.

(a) Information contained in an individual's record shall be disclosed only to authorized Cabinet for Health Service representatives, or authorized representatives of the federal government.

(b) An individual's service record and other information regarding payments claimed shall be maintained in an organized file and furnished to cabinet or federal government personnel upon request for inspection and copying.

(c) Failure of a provider agency to provide the requested documentation to Cabinet for Health Services staff shall result in denial of payment for the billed services.

Section 10. Reimbursement. (1) Rate setting for the fiscal years beginning July 1, 1999 and July 1, 2000 shall be as follows:

(a) For outpatient services provided in accordance with Section 4(3) of this administrative regulation, final prospectively-determined rates for direct service cost centers shall be established on the basis of actual reasonable allowable cost as derived from a provider's audited annual cost report for the prior year prepared in accordance with 908 KAR 2:060, Section 3, and rates shall be determined in accordance with the following:

1. If an audited cost report is not available, the most recent unaudited annual cost report shall be the basis for the final rate.

2. If an unaudited cost report is used to establish rates, these rates shall be adjusted upon audit or desk review of the cost report used in setting the rate.

3. Allowable costs shall be trended to the beginning of the rate year and indexed to the end of the rate year using Standard and Poore's Data Resource, Incorporated (DRI).

4. A base payment rate for each service shall be the lower of the per unit rate derived from a provider's cost report or the maximum base payment rate for that service as established by the Medicaid Program.

5. A maximum base payment rate shall be determined for each service and shall be set at 130 percent of the median cost per unit of service of participating providers.

6. An incentive payment equal to fifteen (15) percent of the amount that a maximum base payment rate exceeds a provider's base payment rate, excluding the incentive payment, shall be paid for facilities with base payment rates under the maximum.

(b) Final rates for services not specified in paragraph (a) of this subsection shall be determined in accordance with the following:

1. The services are as follows:

a. Assessment provided in accordance with Section 4(1) of this administrative regulation;

b. Universal prevention provided in accordance with Section 4(2)(b) of this administrative regulation;

c. Selective prevention provided in accordance with Section 4(2)(c) of this administrative regulation;

d. Indicated prevention provided in accordance with Section 4(2)(d) of this administrative regulation;

e. Intensive outpatient provided in accordance with Section 4(4) of this administrative regulation;

f. Day rehabilitation provided in accordance with Section 4(5) of this administrative regulation;

g. Case management provided in accordance with Section 4(6) of this administrative regulation; and

h. Community-support services provided in accordance with Section 4(7) of this administrative regulation.

2. Rates shall be determined in accordance with the following:

a. An interim rate for each provider shall be established through a budgeted cost report submitted by each provider prior to payment;

b. A separate accounting cost center shall be established by each provider for each direct service identified in subparagraph 1 of this paragraph to record costs incurred;

c. A final rate for each direct service cost center for each year shall be established based on the provider's actual cost report prepared in accordance with 908 KAR 2:060, Section 3, for the years ending June 30, 2000, and June 30, 2001; and

d. A payment based on an interim rate established in accordance with paragraph (b) of this subsection shall be adjusted retroactively to final rates established in accordance with clause c of this subparagraph.

(2) Rate setting for SFY 2002 shall be as follows:

(a) A final prospectively-determined rate for each direct service cost center covered in this administrative regulation shall be established on the basis of actual reasonable allowable cost as derived from the provider's audited annual cost report prepared in accordance with 908 KAR 2:060, Section 3, for the prior year.

1. If an audited cost report is not available, the most recent unaudited annual cost report shall be the basis for the final rate.

2. If an unaudited cost report is used to establish rates, these rates shall be adjusted upon audit or desk review of the cost report used in setting the rate.

(b) Allowable costs shall be trended to the beginning of the rate year and indexed to the end of the rate year using Standard and Poore's Data Resource, Incorporated (DRI).

1. A base payment rate for each service area shall be the lower of the per unit rate derived from a provider's cost report or the maximum base payment rate for that service as established by the Medicaid Program.

2. A maximum base payment rate shall be determined for each service and shall be set at 130 percent of the median cost per unit of service of all participating providers.

3. An incentive payment equal to fifteen (15) percent of the amount that the maximum base payment rate exceeds a provider's base payment rate, excluding the incentive payment, shall be paid for facilities with base payment rates under the maximum.

(3) Effective July 1, 2003, the payment rate that was in effect on June 30, 2002, for community mental health center substance abuse services and remained in effect throughout SFY 2003 shall remain in effect throughout SFY 2004.

(4) Implementation of the payment system.

(a) Reimbursement for services shall be based on the following units of service:

1. Universal prevention service shall be a one-quarter (1/4) hour unit;

2. Selective prevention service shall be a one-quarter (1/4) hour unit;

3. Indicated prevention service shall be a one-quarter (1/4) hour unit;

4. Outpatient service shall be a one-quarter (1/4) hour unit for the following modalities:

a. Individual therapy;

b. Group therapy;

c. Family therapy;

d. Psychiatric evaluation;

e. Psychological testing;

f. Medication management; and

g. Collateral care;

5. An assessment service shall be a one-quarter (1/4) hour outpatient unit;

6. Intensive outpatient shall be a one-quarter (1/4) hour unit;

7. Day rehabilitation services shall be a one (1) hour unit;

8. Case-management services shall be a one-quarter (1/4) hour unit; and

9. Community support shall be a one-quarter (1/4) hour unit.

(b) Overpayments discovered as a result of audits shall be settled through recoupments or withholding of future payments.

(c) A provider shall submit an annual cost report utilizing the Community Mental Health Center Substance Abuse Services Cost Report and its instructions not later than ninety (90) days from the end of the provider's accounting year and shall maintain an acceptable accounting system to account for the cost of total services provided, charges for total services rendered, and charges for covered services provided to Medicaid-eligible individuals.

(d) An audited cost report shall be submitted to the department within six (6) months from the end of the provider's accounting year.

(e) Each provider shall make available to the cabinet at the end of each fiscal reporting period, and at intervals as the cabinet may require, all patient and fiscal records of a provider, subject to reasonable prior notice by the cabinet.

(f) Payments due a provider shall be made at reasonable intervals but not less often than monthly.

(5) Nonallowable costs.

(a) The department shall not reimburse for a service not specified as covered in Section 4 of this administrative regulation.

(b) Reimbursement shall not be made for any portion of a provider's costs found to be unreasonable or nonallowable in accordance with 908 KAR 2:060, Section 3.

(c) Room and board costs shall not be included as an allowable cost for any service defined in Section 4 of this administrative regulation.

Section 11. Reimbursement of Out-of-state Providers. Reimbursement to a participating out-of-state mental health center provider shall be the lower of charges, or a provider's rate as set by the Medicaid Program in the other state, or the maximum base payment rate for that type of service in effect for Kentucky providers.

Section 12. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department decision regarding the Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) A provider may appeal a department decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 13. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Community Mental Health Center Substance Abuse Services Cost Report, May 1994"; and

(b) "Community Mental Health Center Substance Abuse Services Cost Report Instructions, May 1994".

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (26 Ky.R. 1739; Am. 1953; eff. 5-10-2000; 480; 1273; 11-25-03.)